



MARYLAND NATURAL RESOURCES POLICE

Medical Practitioner's Certification of Applicant's Ability to Perform the Maryland Natural Resources Police Functional Fitness Assessment Test



APPLICANT'S NAME: \_\_\_\_\_

Scheduled Date of Functional Fitness Assessment Test (FFAT): \_\_\_\_\_

Dear Medical Practitioner:

The above referenced applicant will be required to participate in the Maryland Natural Resources Police Pre-Employment Functional Fitness Assessment Test (FFAT). The FFAT will be performed under the guidance of Maryland Natural Resources Police Fitness Coordinators and consists of the below elements. Practitioner need only certify that the Applicant may safely participate in:

- \* Push-Ups (Muscular Endurance) • 18 push-ups performed in one minute.
\* Sit-Ups (Muscular Endurance) • 27 bent leg sit-ups performed in one minute.
\* Flexibility (Range of motion of lower back and hamstrings) • Score is in inches reached on a yardstick with the 15" mark at the toes.
\* 1.5 Mile Run (Cardiovascular ) • Performed in less than 15:20.

To be completed by Applicant's Medical Practitioner:

Can perform the FFAT at this time (One box MUST be checked): [ ] Yes [ ] No

If No, anticipated date when applicant can perform: \_\_\_\_\_

MEDICAL PRACTITIONER'S SIGNATURE. (Must be completed in its entirety and personally signed by the applicant's medical Practitioner. Stamped signatures affixed by office personnel on the medical practitioner's behalf are not acceptable.)

I hereby certify that I am a licensed medical practitioner and that I have satisfied and maintained the licensing requirements required for my specialty. I further certify that I have reviewed this applicant's condition in a manner consistent with the prohibitions contained in regulations adopted by the State Board of Quality Assurance or its equivalent. My opinions are based on my personal review of the applicant's examination, and the conclusions reached are based on a reasonable degree of medical certainty. I understand that the State of Maryland Medical Director may contact me regarding the information certified herein.

\*\*\* No Stamps \*\*\*

Practitioner's Signature

Date of Examination

Practitioner's Printed Name

Specialty

License No.

Expiration Date

Address: \_\_\_\_\_

Telephone No.: ( ) \_\_\_\_\_